PRINTED: 10/31/2018 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES			OMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G230	B WING	·	09/21/2018	
	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
DC HEA	LTH CARE		w.	ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
W 000	INITIAL COMMENT	rs	W 000			
	9/19/18 through 9/2 was selected from a survey was conduct fundamental survey. The findings of the sobservations, intervadministrative recording throughout the selection of the sobservations of the sobservations, intervadministrative recording throughout the selection of the survey administrative recording throughout the selection of the survey administrative recording throughout through throug	survey were based on iew, and review of client and ds. e abbreviations that may he body of this report. er ry Team ellectual Disabilities	W 159			
	•	6]. On 9/20/18 at 7:40 AM,				
		ved to have missing teeth.				
	On 9/21/18 at 10:37	AM, the home manager				
ORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	MATURE	TITLE	(YA) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:5I1G11

Facility ID: 09G229

If continuation sheet Page 1 of 4

PRINTED: 10/31/2018

		& MEDICAID SERVICES				APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		09G230	B. WING		09	/21/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	12010	
DC HEA	ALTH CARE			WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 159	stated that Client #2 client was mostly de twice daily but preve by biting down on the confirmed that staff client in tooth brush  On 9/21/18 at 10:40 on Client #2's denta the client was histor treatment services. submitted a preauth conscious sedation also stated that she record to determine services from the deformed at 10:52 AM dentist wrote Client fillings but the requereview of the record dentist documented denied and would be the reason for the dedid not know the real also stated that he dauthorization with the able to provide docudiscussion or coordinatthe QIDP coordit to address Client #2'	had about five teeth left. The ependent for tooth brushing ented thorough tooth brushing e toothbrush. The QIDP was required to assist the ing twice daily.  AM, the RN was consulted I health. The RN stated that ically uncooperative for dental She added that the dentist orization request for deep more than a year ago. She would review the client's when the client last received entist.  AM, the QIDP confirmed that d a prior authorization request sedation. Review of the showed on 1/3/18 that the st was still pending. Further showed on 8/13/18, the that the previous request was a resubmitted. When asked elay, the QIDP stated that he son for the delay. The QIDP	W 159	An inservice training was co on 09/24/18 with QIDP and by DON/PM on coordination services, process of authoriz documentation and implementation are views to ensure services a coordinated as written/order (Please see Attachment A1)	RN/LPN of cation, intation. ed on cing andom ire	9/24/18 & 10/22/18	

dental restoration.

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		AND HOWAIN SERVICES			FORM APPROVED
		& MEDICAID SERVICES		0	MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G230	B WING_		09/21/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0012112010
DC HEA	LTH CARE			WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE COMPLETION
W 356	COMPREHENSIVE CFR(s): 483.460(g)	DENTAL TREATMENT (2)	W 35	6	
	treatment services t needed for relief of	sure comprehensive dental that include dental care pain and infections, and maintenance of dental		e!	
	Based on observation review, the facility fareceived dental treat	not met as evidenced by: ion, interview and record liled to ensure each client tment services, including for one of three clients in the			c
	Findings included:				
	have missing teeth.	AM, Client #2 was observed to		An inservice training was compon 09/24/18 with QIDP and RN by DON/PM on coordination of	V/LPN &
	stated that Client #2 The client was most brushing twice daily, brushing by biting do	AM, the home manager only had about five teeth left. ly dependent for tooth but prevented thorough tooth own on the toothbrush. The t staff was required to assist ushing twice daily.		services, process of authorizated documentation and implement The procedure was completed 10/22/18 for client #2 (receivin treatment). QA/PM will do ran reviews to ensure services are coordinated as written/ordered	tion, ration. I on g dom
İ	regarding the status The RN stated that the uncooperative for de added that the dentis request more than a	AM, the RN was consulted of Client #2's dental health. he client was historically ental treatment services. She at submitted an authorization year ago for deep conscious client. She further stated that		(Please see Attachment A1 &	A2)

dentist.

she would review the client's record to determine when the client last received services from the

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		E & MEDICAID SERVICES	2-51-552			KM APPROVEI IO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) E	(X3) DATE SURVEY COMPLETED	
		09G230	B WING			9/21/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	7372 1720 10	
DC HEA	LTH CARE			WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W 356	Continued From pa	age 3	W 35	66			
	On September 21, 2018, at 10:52 AM., record review revealed the following information concerning Client # 2's dental health:						
	(1) 1/3/18 - The dentist wrote, "Update for deep conscious sedation. We checked the status of the preauthorization approval for deep conscious sedation. It is pending. We will call to reschedule once returned. The patient needs fillings."						
	(2) 8/13/18 - Dentist wrote "Patient did not allow me to examine oral structures. The patient refused any treatment. The patient needs to be treated under deep conscious sedation. The previous request was denied. However, we are resubmitting documentation. We will call to reschedule the next appointment."  At the time of the survey, there was no evidence the facility followed up with the dentist between the aforementioned dates to obtain the status of recommended deep conscious sedation required to perform Client #2's needed fillings.						
				¥			

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CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G230	B WING		09/21/2018	
NAME OF PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	03/2/1/2016	
DC HEA	LTH CARE		WA	ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
E 000	Initial Comments		E 000			
	An emergency pre conducted from 9/1	paredness survey was 9/18 through 9/21/18.				
	interviews and revier preparedness progretermined that the compliance with the Requirements for Marticipation for Interviews	survey were based on ew of the emergency ram. The survey findings a facility was in substantial as Emergency Preparedness Medicare and Medicaid ermediate Care Facilities for ellectual Disabilities (ICF/IID). The cited.				
/						
DRATORY E	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	The same of the sa		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5I1G11

Facility ID: 09G229

	regulation & Licensin	ng Administration				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0256		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
		B. WING _		09/21/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	STATE, ZIP CODE		
DC HEAL	TH CARE		GTON, DC			
040.15	CLIMMADY CTA	TEMENT OF DEFICIENCIES				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED FOR THE APPRO	D BE COMPLETE	
1 000	INITIAL COMMENT	rs .	1 000			
	A licensure survey through 9/21/18. A selected from a pop	was conducted from 9/19/18 sample of three residents was pulation of six men.				
	The findings of the sobservations, intervand administrative r	survey were based on iews, and review of resident ecords.				
Α)	Note: The below ar appear throughout t	e abbreviations that may he body of this report.		-		
	GHIID - Group Hom Intellectual Disabiliti HM - Home Manage					
	IDT - Interdisciplinary Team QIDP - Qualified Intellectual Disabilities Professional					
	RN - Registered Nu	rse				
I 180	3508.1 ADMINISTR	ATIVE SUPPORT	l 180			
	Each GHMRP shall administrative suppo needs of the resider Habilitation plans.	provide adequate ort to efficiently meet the its as required by their				
	Based on observation	net as evidenced by: on, interview and record led to coordinate a delayed		An inservice training was completed	9/24/18	
1	treatment services, f	uthorization for sedation to complete dental ment services, for one of three residents in cample (Resident #2).		on 09/24/18 with QIDP and RN/LP by DON/PM on coordination of services, process of authorization, documentation and implementation	10/22/18	
I	Findings included:			The procedure was completed on 10/22/18 for client #2 (receiving treatment). QA/PM will do random	•	
	[Cross refer to I0401]. On 9/20/18 a Resident #2 was observed to have			reviews to ensure services are coordinated as written/ordered.		
On 9/21/18 at 10:37 AM, the home manager			(Please see Attachment A1 & A2)			

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PROGRAM DIRECTOR

(X6) DATE 11/10/18

STATE FORM

511G11

If continuation sheet 1 of 4

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING COMPLETED HFD03-0256 09/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DC HEALTH CARE WASHINGTON, DC 20011 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 1 180 Continued From page 1 1180 stated that Resident #2 had about five teeth left. The resident was mostly dependent for tooth brushing twice daily but prevented thorough tooth brushing by biting down on the toothbrush. The QIDP confirmed that staff was required to assist the resident in tooth brushing twice daily. He stated that no system was implemented to monitor the resident's tolerance of daily tooth brushing prior to the survey. On 9/21/18 at 10:40 AM, the RN was consulted on Resident #2's dental health. The RN stated that the resident was historically uncooperative for dental treatment services. She added that the dentist submitted a preauthorization request for deep conscious sedation more than a year ago. She also stated that she would review the resident's record to determine when the resident last received services from the dentist. A follow-up with the QIDP confirmed that the dentist submitted a prior authorization request for deep conscious sedation. However, on 1/3/18 the dentist wrote that Resident #2 continued to need the fillings but the request was still pending. On 8/13/18, the dentist updated that the previous request was denied and would be resubmitted. When asked the reason for the delay, the QIDP stated that he did not know the reason for the delay. The QIDP stated that he discussed the prior authorization with the IDT. However, the QIDP was not able to provide documentation of the IDT discussion or coordination of Resident #2's prior authorization. At the time of the survey, there was no evidence that the QIDP coordinated services with the IDT to address Resident #2's delayed preauthorization for deep conscious sedation

recommended for dental restoration.

511G11

Health Regulation & Licensing Administration								
STATEMENT O AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		HFD03-0256	B. WING		09/21/2018			
NAME OF PRO	VIDER OR SUPPLIER	STREET AL	DORESS, CITY,	STATE, ZIP CODE				
DC HEALTH	CARE	WASHING	GTON, DC 20	0011				
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE			
Property of the service of the servi	ofessional service devaluation, incluvelopmental level rvices, and service terioration or furth sident.  is Statute is not resed on observationiew, GHIID failed beived timely dent sidents in the same adings included:  19/20/18 at 7:40 A served to have mile served to have designed that resident in tooth services. She added the horization requests to conscious sed a further stated the	es shall include both diagnosis uding identification of la and needs, treatment es designed to prevent ner loss of function by the met as evidenced by: on, interview and record to ensure each resident all treatment services, of teeth, for one of three aple. (Resident #2)  AM, Resident #2 was issing teeth.  AM, the home manager #2 only had about five teeth is mostly dependent for tooth but prevented thorough tooth own on the toothbrush. The it staff was required to assist brushing twice daily.  AM, the RN was consulted of Resident #2's dental and that the resident was rative for dental treatment that the dentist submitted and the more than a year ago for attion to treat the resident. At she would review the determine when the resident	I 401	An inservice training was comple on 09/24/18 with QIDP and RN/L by DON/PM on coordination of services, process of authorization documentation and implementation. The procedure was completed or 10/22/18 for client #2 (receiving treatment). QA/PM will do rando reviews to ensure services are coordinated as written/ordered.  (Please see Attachment A1 & A2	.PN & 10/22/18 n, on. n			
		s from the dentist.						

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: HFD03-0256 B. WING 09/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DC HEALTH CARE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1401 Continued From page 3 1401 On September 21, 2018, at 10:52 AM., record review revealed the following information concerning Resident #2's dental health: (1) 1/3/18 - The dentist wrote, "Update for deep conscious sedation. We checked the status of the preauthorization approval for deep conscious sedation. It is pending. We will call to reschedule once returned. The patient needs fillings." (2) 8/13/18 - Dentist wrote "Patient did not allow me to examine oral structures. The patient refused any treatment. The patient needs to be treated under deep conscious sedation. The previous request was denied. However, we are resubmitting documentation. We will call to reschedule the next appointment." At the time of the survey, there was no evidence the GHIID followed up with the dentist between the aforementioned dates to obtain the status of recommended deep conscious sedation required to perform Resident #2's needed fillings.